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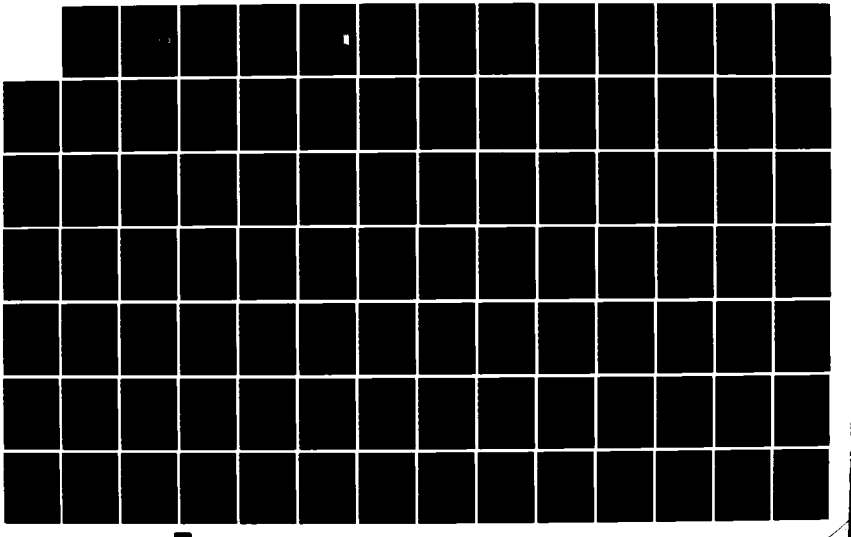

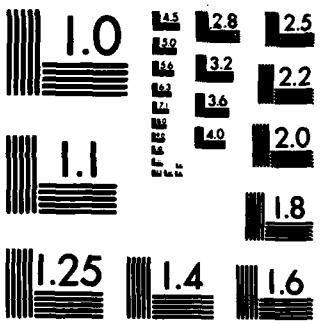

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THESIS ABSTRACT

THE OHIO STATE UNIVERSITY
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NAME: Diana L. Kupchella QUARTER/YEAR: Summer/1984

DEPARTMENT: Nursing DEGREE: Master of Science

TITLE OF THESIS: Leader Behavior of Head Nurses Through the Perceptions of Self and Others

Summarize in the space below the purpose and principal conclusions of your thesis.

Using the theory of Situational Leadership by Hersey and Blanchard (1982), this study was conducted to describe leader behaviors of Medical-Surgical Head Nurses (MSHNs) in Central Ohio. Eight hypotheses were tested concerning the dominant leadership styles, range of leadership styles and maturity levels of MSHNs. The sample consisted of 30 MSHNs, as well as, the immediate superior and three subordinates for each MSHN. Participants completed the Leadership Effectiveness Adaptability Description (LEAD), the Head Nurse Maturity Scale and a Personal Inventory Tool. Data were collected over a five week period and were analyzed using means, percentages and Fisher's Exact Test of Probability. Major findings, based on the perceptions of self and others, indicate that the dominant leadership style for MSHNs is High Task/High Relationship, the range of leadership styles includes three of the four possible styles and low relationship leadership styles are rarely used by MSHNs. In addition, maturity levels of MSHNs were found to be moderately high and having no significant relationship to the leadership styles demonstrated. The findings of this study add validity to the findings of an earlier study of the leader behaviors of Emergency Department Head Nurses in Virginia.

Joanne O. Clement
Adviser's Signature

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AUTHOR: Diana L. Kupchella

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LEADER BEHAVIOR OF HEAD NURSES THROUGH THE PERCEPTIONS OF SELF AND OTHERS

A Thesis

Presented in Partial Fulfillment of the Requirements

for the Degree Master of Science

by

Diana L. Kupchella, BSN, MEd.

The Ohio State University

1984

Approved by

Jeanne C. Clement
Advisor

Department of Nursing

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Chapter I

Introduction and Theoretical Framework

Leadership is a highly desirable quality in the field of nursing. Nursing literature has cited a need for leadership (DeVincenti, 1972; Eckvahl, 1976; LaMonica and Finch, 1977; Leininger, 1974; O'Donovan, 1975; Zorn, 1977). By virtue of their position, head nurses are leaders, and as such, are responsible for developing leadership in their staff. If leadership behaviors are to be cultivated in nursing, it is important to know how leadership is currently being practiced. Only one study describing the leadership behaviors of head nurses has been conducted (Ausen, 1980).

Statement of the problem

The purpose of this study is to replicate, using a different population, a nursing leadership study examining self-perception and other-perception of leadership behavior, dominant leadership style, and maturity level of head nurses. This study will answer the following questions: How do head nurses of hospital medical-surgical units perceive their own leadership behavior and how do others perceive this behavior? How do Task Behavior and Relationship Behavior indicate a dominant style of leadership and a range of leadership styles? How do head nurses perceive their own Maturity Level and how do others perceive it? To what extent do these self-perceptions correlate with the perceptions of others? What correlation exists

between dominant leadership style and maturity? What correlation exists between range of leadership style and maturity? Further, how do these findings compare to those found by A. Marlene Ausen (1980)?

Hypotheses

Although Ausen (1980) did not state hypotheses in her study, the following hypotheses are derived from her findings.

1) The dominant leadership style of head nurses as both self- and other-perceived is High Task/High Relationship (HT/HR).

2) There is a high degree of correlation between self-perception and other-perception of the dominant leadership style of head nurses.

3) The range of leadership styles exhibited by head nurses, as both self and other perceived, includes all four of the leadership styles described in Situational Leadership Theory (Hersey and Blanchard, 1982).

4) There is a high degree of correlation between self-perceived and other-perceived range of leadership styles of the head nurse.

5) The Maturity Levels of head nurses as perceived by self and others is high.

6) There is a high degree of correlation between the self-perceived and other-perceived Maturity Levels of head nurses.

7) There is a low degree of correlation between the dominant leadership style of head nurese and their Maturity Level as perceived by themselves and others.

The following additional hypothesis was not directly addressed in

Ausen's (1980) study.

8) There is a high degree of correlation between Maturity Level and range of leadership styles of head nurses.

Definition of terms

In order to replicate Ausen's (1980) study describing leader behavior of head nurses, the definition of terms are taken from her study (p. 6-7) and are defined here.

Leadership Style: "The behavior pattern that an individual exhibits when attempting to influence the activities of others as perceived by those others"; it "involves some combination of either task behavior or relationship behavior" (Hersey and Blanchard, 1977, p. 103), as measured by the Leader Effectiveness Adaptability Description (LEAD) instruments, both Self and Other.

Maturity: In relation to a specific task to be performed, it is the ability and willingness of an individual to take responsibility for directing his or her own behavior (Hambleton, et al., 1977, p. 4). In this paper the term will be used to incorporate both job and psychological maturity; it is synonomous with Total Maturity and will be measured by the Head Nurse Maturity Scale.

Job Maturity: The individual's ability or competence to perform a task; the individual has the knowledge, ability and experience to do the task without direction from others (Hambleton, et al., 1977, p. 4). Job Maturity will be determined by the Job Maturity score on the Head Nurse Maturity Scale.

Psychological Maturity: The individual's willingness or motivation to perform a task; the individual believes his or her responsibility for the task is important and has self-confidence and good feelings about him or herself; the individual does not need "psychological strokes" or encouragement to do the job (Hambleton, et al., 1977, p. 4). Psychological Maturity will be determined by the Psychological Maturity score on the Head Nurse Maturity Scale.

Relationship Behavior: "The extent to which leaders are likely to maintain personal relationships between themselves and members of their group (followers), by opening up channels of communication, providing socioeconomic support, 'psychological strokes', and facilitating behaviors" (Hersey and Blanchard, 1977, p. 194). Relationship Behavior is measured by the LEAD-Self and LEAD-Other instruments.

Strength of Style: The frequency with which a specific leadership style as indicated on the LEAD (Self and Other) instruments.

Task Behavior: "The extent to which leaders are likely to organize and define the roles of the members of their group (followers)"; it is "characterized by endeavoring to establish well-defined patterns of organization, channels of communication, and ways of getting jobs accomplished" (Hersey and Blanchard, 1977, p. 103-104). Task Behavior is measured by the LEAD (Self and Other) instruments.

Theoretical framework

In order to study the leadership behaviors of head nurses, a theoretical framework is needed. The one selected for this study is

that of Hersey and Blanchard (1969, 1972, 1977, 1982), who developed Situational Leadership Theory. Leadership is defined by Hersey and Blanchard (1982) as the behavior used in "the process of influencing the activities of an individual or group in efforts toward goal achievement in a given situation (p. 83). According to this theory, leaders cannot be effective unless they can adapt their leadership style to a given situation. Leadership style is the behavioral pattern exhibited by the leader "when attempting to influence the activities of others as perceived by those others"; it "involves some combination of either task behavior or relationship behavior" (Hersey and Blanchard, 1982, p. 96). The major variables to be considered are the task behavior and the relationship behavior exhibited by the leader toward the followers.

Task behavior is "the extent to which leaders are likely to organize and define the roles of the members of their group (followers); to explain what activities each is to do and when, where, and how tasks are to be accomplished, characterized by endeavors to establish well-defined patterns of organization, channels of communication, and ways of getting jobs accomplished" (Hersey and Blanchard, 1982, p. 96). Relationship behavior is "the extent to which leaders are likely to maintain personal relationships between themselves and members of their group (followers) by opening up channels of communication, providing socioeconomic support, 'psychological strokes' and facilitating behaviors" (Hersey and Blanchard, 1982, p.96). A leadership

style characterized as High Task/Low Relationship (HT/LR) involves the leader providing specific instructions and closely supervising the followers, or simply telling them what to do. A High Task/High Relationship (HT/HR) style would mean the leader explains decisions and provides opportunities for clarification, or sells the task to the followers. Using a Low Task/High Relationship (LT/HR) style, the leader shares ideas and facilitates decision-making, or participates in the task with the followers. Finally, with a Low Task/Low Relationship (LT/LR) style the leader turns over responsibility for decisions and implementation to the followers, or delegates.

Hersey and Blanchard (1977) also relate the style of effective leadership behavior to the maturity level of the followers. Maturity is defined in terms of willingness (motivation) and ability (competence) to do a specific task. Maturity in this sense is composed of two factors, job maturity or the "ability and technical knowledge to do the task", and psychological maturity or the "feeling of self-confidence and self-respect about oneself as an individual" (p. 163).

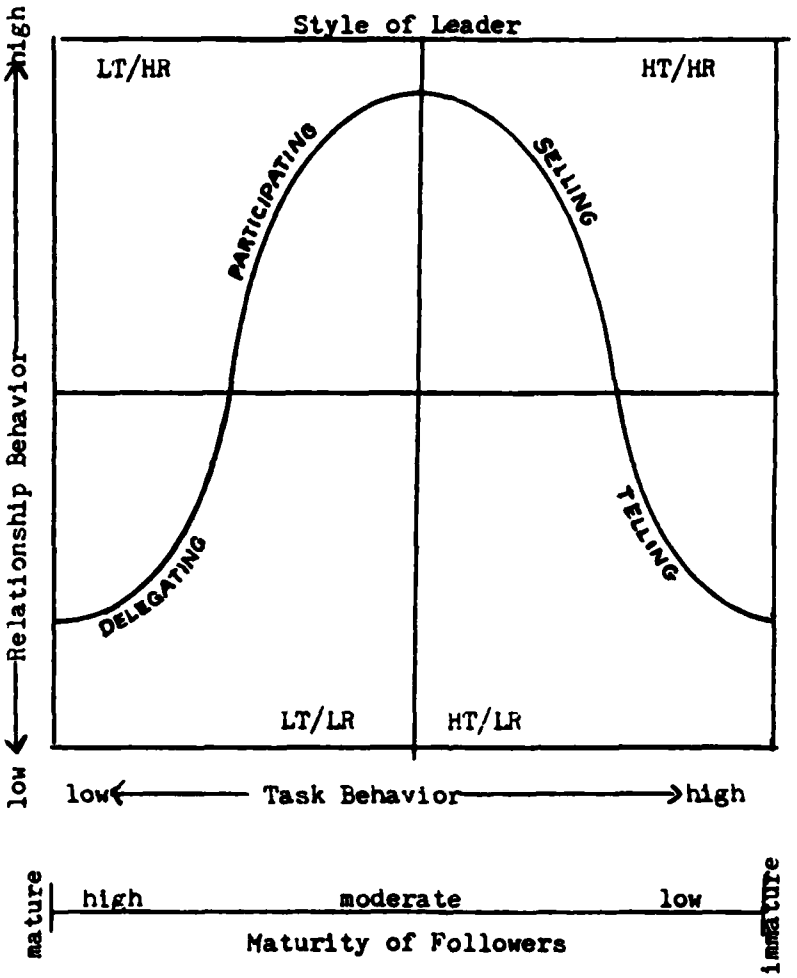
According to Situational Leadership Theory, the effective leader will adapt his/her leadership behavior to the maturity of the followers. As the maturity level of the followers increases, leaders should reduce their task behavior and increase their relationship behavior until the followers achieve a moderate level of maturity. As the followers achieve a high level of maturity, the effective leader will decrease both task and relationship behaviors. Close supervision and positive reinforcements by the leader are no longer necessary and an increase in delegation by the leader is perceived as a positive indication of

trust and confidence in the followers. This relationship between leadership style and maturity of the followers is a curvilinear relationship as illustrated in Figure 1.

Hersey and Blanchard (1982) acknowledge that although the maturity of the followers can be a useful tool in determining the appropriate style of leadership, there are other situational variables to be considered, such as the supervisor's leadership style, a crisis or time limit, the nature of the work, etc. Ausen (1980) chose to examine the influence of the maturity level of the leader him/herself on the style of leadership manifested, thus to determine if "Maturity of Leader" could be substituted for "Maturity of Followers" in Figure 1.

Hersey and Blanchard (1982) further contend that the effective leader is able to diagnose his/her environment. This environment consists of the leader, the followers, the superiors, associates, the organization and the job demands. Each of these components, with the exception of job demands, has two major components - style and expectations. The leader's style is defined as "the consistent behavior patterns that they (the leaders) use when they are working with and through other people as perceived by those people" (p. 126). As the leaders consistently behave in the same manner to similar situations their behavior patterns become predictable. "Expectations are the perceptions of appropriate behavior for one's own role or position or one's perceptions of the roles of others within the organization" (p. 126). It may be concluded then, that perceptions influence the effectiveness or ineffectiveness of the leader's behavior.

Figure 1: Situational Leadership

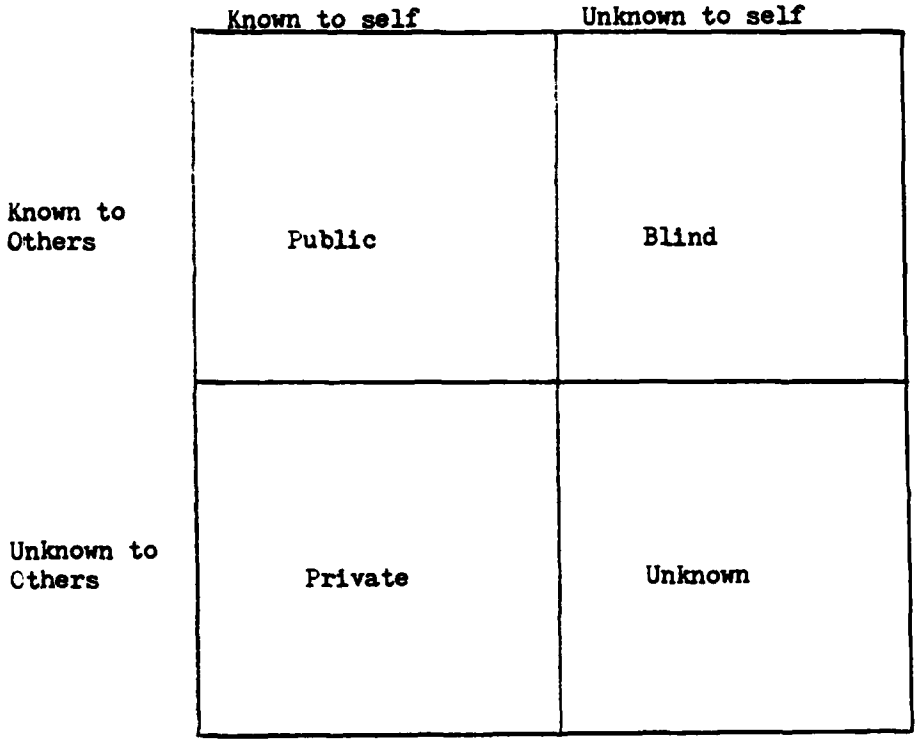


(Hersey and Blanchard, 1982, p. 248)

To describe leader behavior through perceptions, Hersey and Blanchard (1982) made use of a model developed by Luft and Ingham (1955) called the Johari Window. The Johari Window is a model containing four quadrants: Public, Blind, Private and Unknown (see Figure 2). As Hersey and Blanchard (1982) apply this model to leaders, the Public quadrant contains things known to both the leader and others; the Blind quadrant contains things known to others but unknown to the leader; the Private quadrant contains things known to the leader but unknown to others; and the Unknown quadrant contains things unknown to either the leader or to others. Thus, self-perceptions are known in the Public and Private quadrants, whereas others-perceptions are known in the Public and Blind quadrants. An adequate measure of perceptions then, would include both self-perceptions and other-perceptions. In Situational Leadership Theory, Hersey and Blanchard (1982) recognize the importance of consistency between self-perceptions and other-perceptions of leadership behavior for leadership effectiveness.

In summary, Situational Leadership Theory (Hersey and Blanchard, 1982) proposes that leadership behaviors are composed of varying degrees of task and relationship behaviors. Leadership behaviors are observed by the leaders themselves as well as those others around them. To obtain an accurate description of leadership behavior, the investigator must measure both task and relationship behaviors of the leader as perceived by both the leaders themselves and the others around them.

Figure 2: The Johari Window



(Hersey and Blanchard, 1982, p. 240)

Chapter II

Review of the Literature

In this chapter a review of the literature will be presented. To date, nursing literature with the exception of Ausen (1980) has not described nursing leadership behavior through the use of Situational Leadership Theory. A complete review of the literature up to 1980 can be found in the Master's Thesis by Ausen (1980, pp. 10-39). This section of this paper will summarize, critique and update the literature. This summary will include the historical development of leadership theory, including women as leaders, and nursing leadership studies.

Historical development

As one reviews the literature, as well as Hersey and Blanchard's Situational Leadership Theory, it may be noted that the terms leadership and management become confused. There is some overlap of concepts and it would seem that leadership theory evolved from management theory. However, Hersey and Blanchard (1982) do distinguish between the two concepts.

> Management is thought of as a special kind of leadership in which the achievement of organizational goals is paramount. The key difference between the two concepts, therefore, lies in the word organization. Leadership occurs any time one attempts to influence the behavior of an individual or group, regardless of the reason. It may be for one's own goals or those of others, and they may or may not be congruent with organizational goals (p. 3).

The concepts of management and leadership in this study are congruent with this definition.

Frederick Winslow Taylor (1911, 1939, 1947) started the Scientific Management Movement and thus was one of the earliest theorists of leader behavior. Through numerous time and motion studies, Taylor determined that the workers' primary interest in the organization was higher wages. The primary interest of the organization was to receive maximum output from the workers at the lowest possible cost. It was the responsibility of management to ensure that the organizational needs were met. They were to do this by developing a science for each element of the workman's job; what and how a job was to be done and the length of time required to do it. It was assumed that as managers cooperated with the workers, the work would be performed within this scientific framework. Little attention was focused on the needs of the individual.

In contrast to this movement, Elton Mayo (1933) started the Human Relations Movement. Mayo believed that if workers had positive feelings about their work and their work relationships, production would increase. The manager's job, was to provide an environment of positive relationships for the workers. The workers, rather than the organization were the focus of this movement.

Although approaching leadership behavior from opposing frameworks, these two theories have influenced the perceptions of leadership behavior to the present day. Other theorists have approached the subject by combining Taylor's and Mayo's views. Tannenbaum and Schmidt (1957), for example, displayed leadership behavior as a range

of styles on a continuum with authoritarian style on one end and democratic style on the other.

McGregor (1960) considered the theories of Taylor (1911, 1939, 1947) and Mayo (1933) and devised his well-known Theory X and Theory Y approach to management. Theory X assumed that people are basically lazy and unreliable and are motivated by physiological and safety needs as described by Maslow (1954). The role of manager (leader) was to control and supervise the workers directly. Theory Y assumed that workers were also motivated by social, esteem and self-actualization needs, also described by Maslow (1954). The role of manager (leader) in this instance, was to support and therefore motivate the workers.

Argyris (1971) looked at the leaders behavior in relation to Theory X and Y and derived what he called Behavior Pattern A and Behavior Pattern B. Using Behavior Pattern A, the leader would provide high structure in the work environment and tell the workers what to do (corresponding to Theory X). In contrast, Behavior Pattern B provides for the leader to show high consideration, general supervision and active participation with the workers. Argyris (1971) also acknowledged the self-fulfilling prophesy, indicating that when leaders treat their workers with specific expectations, the workers will perform accordingly (Guest, Hersey, and Blanchard, 1977).

In 1945, an attempt was made to define and describe leadership, by a group at Ohio State University. It was believed that one needed to define and describe before one could predict leadership (Hemphill

and Coons, 1957; Shartle, 1957). The definition of leadership behavior that was developed was "the behavior of an individual when he is directing the activities of a group toward a shared goal" (Hemphill and Coons, 1957, p. 7). Two aspects of leadership were described: Initiating Structure and Consideration. Initiating Structure was defined as "the leader's behavior in delineating the relationship between himself and members of the work group and endeavoring to establish well-defined patterns of organization, channels of communication, and methods of procedure" (Halpin, 1959, p. 4). Consideration was defined as "the behavior indicative of friendship, mutual trust, respect, and warmth in the relationship between the leader and members of his staff" (Halpin, 1959, p. 4). To describe these aspects of leader behavior through perceptions, the Leader Behavior Description Questionnaire (LBDQ) and the Leader Opinion Questionnaire (LOQ) were developed. It was from these studies that Hersey and Blanchard (1969, 1972, 1977, 1982) eventually derived their theories of Task Behavior and Relationship Behavior.

Reddin (1967, 1970) and Fiedler (1967) added to the already existing theories, the dimension of effectiveness of leadership based on the situation. Fiedler (1967) saw three variables in each leadership situation: 1) the relationship of the leader to the followers; 2) the nature or amount of structure of the task; and 3) the power of the leader. He further defined leader behavior in terms of task-orientation and relationship-orientation. A favorable situation for the leader and his/her subsequent effectiveness was dependent upon the three variables being favorable. His model was called the Leader Contingency Model.

An accumulation of all these theories resulted in Situational Leadership Theory as developed by Hersey and Blanchard (1969, 1972, 1977, 1982).

Women as leaders

It is an obvious fact in the United States that the majority of nurses are women. Indeed, the nursing profession from the time of Florence Nightingale, has been traditionally a female occupation. Before reviewing the literature on nursing leadership, then, it is appropriate to identify the general state of female leadership in organizations.

Heller (1982) notes that all of the leadership research done to develop leadership theories through to the Ohio State Leadership Studies, used all male samples. Bartol (1973) agrees that research on female leadership has been "grossly neglected" (p. 34). Heller questioned the validity of applying the resultant leadership standards to women. She conducted a study comparing men and women in organizational roles and found women described as "too focused on people", "emotionally demonstrative", and "not assertive", however, they were also "more humane", "open, friendly". "egalitarian" and "efficient and organized" (p. 10).

Other studies have shown that as either men or women successfully climb the organizational ladder their leadership styles become the same (Bryant, 1983; Grimes, 1983). In addition, Barati (1982) in comparing preferred leadership styles among college men and women, found the preferred styles to be quite similar. The differences in leadership styles between men and women seems to be predominantly among those at the more inexperienced end of the organizational hierarchy.

Heller (1982) attributes these sex differences to differences in sex-role socialization. The styles of novice leaders, just beginning to be socialized to the organization's management roles,may be more influenced by their past sex socialization than by what has shown to be successful leadership styles. Whether or not these styles are learned and practiced would seem to determine success (Grimes, 1983; Bryant, 1983).

In the process of learning new leadership styles, women have an additional problem. They are faced with a role-conflict if their current familiar style of behaving and that which is expected of them as leaders, are different. "One kind of role conflict exists when the female leader's co-workers (subordinates, peers, superiors) have conflicting expectations of how a woman should behave and how a leader should behave. This conflict will be communicated to the leader, creating a lack of clarity as to how she is expected to behave in her leadership position" (Heller, 1982, p. 6; Katz and Kahn, 1966). According to Kosinar (1981) women are socialized toward the care and nurturance of others, "curbing exuberance, loudness and aggression; being attractive; being chosen; following the direction of authority; being well-liked by others; learning to do things as they <u>should</u> be done; marrying and having children" (p. 33). When conflicts are experienced with the new expectations of leadership, women may have to face the question of whether they are becoming masculine by being successful (Kosinar, 1981). Hennig and Jardim (1977) also studied some of the sacrifices of femaleness that women must make in order to succeed in the business world and agreed with these views. After

studying the fear of success among women, Horner (1960) concluded that women who exhibited a high fear of success also tended to have high intelligence and academic success, suggesting that women do experience conflicts in organizational leadership situations.

Some recent studies have added support to the issues of limited leadership styles among novice female managers and sex-role socialization. Bryant (1983) studied a group of female vocational teachers and administrators and found their dominant leadership style to be high task/high relationship. The administrators, however, had a broader range of styles. Golub and Cantz (1982) found that when males and females were paired and given a task in which one had to assume a leadership position, it was most often the male who assumed it or if he did not, it was given to him by the female, apparently in accordance with society's sex role norms. Magargee (1969) also studied the influence of sex-role on leadership behavior and found that even highly dominating women succumbed to the male in a leadership situation.

In summation, female nurses might be expected to exhibit the same leadership conflicts that have been found in women in general, sex-role norms versus leadership expectations. It might also be expected that they display a dominant high task/high relationship leadership style at the first levels of nursing management.

Nursing leadership studies

The concept of nursing leadership is viewed from many perspectives in the literature. The exact nature of leadership behavior of head nurses through both self-perceptions and perceptions of others, however, has not been extensively documented. Whereas there is much information

on the other aspects of nursing leadership, such as personality traits.

Several authors studied the personalities and characteristics of nurse leaders. Gilbert (1975) with a sample of 70 graduate students in nursing believed that she was able to distinguish the personality traits of leaders from the personality traits of non-leaders. The traits of leaders, she contends, are communication skills, aggressiveness, ambitiousness, high capacity to attain status, poise, self-confidence, tolerance for the views of others, high need for achievement, a well-oriented mind, sensitivity to others needs, and flexibility. It could be that these traits are personality traits of graduate students and not necessarily nursing leaders, as not all nursing leaders are graduate students.

Dyer, et al. (1972) studied the relationship between different aspects of clinical performance and personal history, personality, and perceptions of administrative climate in 31 Veterans' Administration Hospitals. Staff nurses viewed head nurses as creating a positive administrative climate when they were willing to be helpful to patients and staff; reasonable when delivering constructive criticism; open about their decisions; willing to eat with staff, and; patient when dealing with difficult patients. However, there was no assessment as to whether these behaviors were appropriate to the situation.

Kelly (1974) attempted to identify personality traits which would predict leadership potential, determined by those who were promoted. He identified three traits which differentiated nurses who were promoted from those who were not: femininity, a capacity for status, and a relaxed demeanor. Effective leadership behavior and promotability,

however, may not be the same.

Other writers (Colton, 1976; LeRoux, 1976; Voudsen, 1979; Carr, 1980; Nyberg, 1982; Wilkinson, 1982) express opinions of personality traits and qualities contributing to the effectiveness and credibility of nurse leaders based on observations, but not empirically tested.

Beck (1976) studied the relationship between personality type and managerial style. With a sample of 66 staff nurses and 31 supervisor nurses, she found that staff nurses were high-relationship oriented, whereas supervisors were more task oriented in their relationships. Data in this study were obtained by self-report inventories.

As viewed from the perspective of Hersey and Blanchard (1982), research using the trait approach to leadership has revealed few consistent findings. It also implies that leadership traits are something one is born with or inherits and not something one learns.

The effects of nursing leadership styles have also been investigated. In a study of 319 subordinates and 87 nurse leaders in nine hospitals, Harpine (1976) found that nurse leaders responded to subordinate feedback with a leadership style that included greater consideration and responsible behavior. This in turn, led to greater job satisfaction for the leader and subordinates.

Bassford and White's (1977) work with Fiedler's Contingency Model in a 340 bed hospital, led them to believe that it is possible to match leadership style of supervisors with the followers attitudes toward leadership, assuming that both are unchangeable. To ensure goal performance and therefore effective leadership they would alter the leaders with the groups. Although they attempted to match

leadership styles with situations, it seems that they denied that the situations in any one work environment may change from one moment to the next, thus requiring flexibility in leadership styles.

White (1971) studied how the leadership style of supervisory nurses affected employees. He found that employees were more secure when allowed to participate in decision-making and less secure when they were simply told what to do. Perhaps in this instance the authoritarian style was inappropriate to the situation. Leininger (1974) suggests that further research in the area of leadership styles and effectiveness could provide strategies for nurses to remain in the nursing profession.

Levenstein (1981) cites a paper presented by Schwartz and Rosener to a meeting of NOW (National Organization for Women) in which they characterize leadership styles to be Alpha (masculine) or Beta (feminine). Leadership style was considered Alpha if it were analytical, rational, quantitative, relied on hierarchial relationships and favored engineered solutions. Whereas a Beta leadership style was characterized by use of intuition rather than rationality, a concentration on qualitative rather than quantitative factors, concerned about growth, reliant on support relationships to obtain action and future oriented. The authors believed that the differences in these leadership styles resulted from socialization of the sexes. Moore and Rickel (1980) examined these two aspects of leadership style by studying the style characteristics of women in traditional and non-traditional managerial roles.

Guy (1982) and Kepler (1980) both write about the need for nurse

leaders to match their leadership styles to the situation to ensure effectiveness. In the previously cited studies the relationship of leadership style to situation was not evaluated.

Some investigators studied leader behaviors, but from only one perspective. For example, Pryer and Distefano (1971) studied the perceptions of leadership behavior and job satisfaction across three levels of nursing. The perceptions studied were those of the subordinates concerning the supervisor. The perceptions of the supervisors on their own behavior was not studied. Job satisfaction was related to Consideration behaviors at all levels; only the non-professional workers related job satisfaction with Initiating Structure behaviors.

Several investigators related job satisfaction with effective leadership behavior (Johnson, 1981; Aftahi, 1981; Payne, 1982), however, there seems to be little agreement as to exactly what that behavior is. It may be, as suggested by Situational Leadership Theory, that nurses want their leaders to be flexible and adaptable to individuals and situations. In her quest for an ideal leadership style among nursing students, Castillo (1983) could not identify a "best model". However, she was able to identify a "best" for followership style. Since her entire sample was nursing students, it is likely that a majority of them were female.

Leadership styles have also been related to the quality of patient care. De Biase (1983) used the Ohio State Leadership Theory and determined that the quality of patient care given was significantly

related to the staff nurses' perceptions of the head nurses' structure behavior, but not significantly related to consideration behavior. Both head nurses and staff nurses perceptions were measured.

Smith (1974) examined the self-perceptions of head nurses, clinical nurse specialists, nursing educators and nursing office personnel concerning their performance in selected nursing activities. She found little aggreement among these nurses as to what their specific nursing functions were or should be. No examination was made as to the perceptions of their subordinates or superiors.

Kelley (1970) studied the perceptions of registered nurses at various levels and nursing students of leadership behaviors important for nursing supervision in a general hospital. Again there was no attempt to relate these behaviors to the situation requiring leadership or the self-perceptions of the leaders. The conclusion, however, was that Group-Centered Behavior versus Goal-Setting, Individual-Centered, Leader-Centered, or Goal-Achieving Behaviors was most important in the practice of nursing supervision.

South (1981) developed the "Nursing Questionnaire" to determine what nurses considered nursing leadership behaviors to be. The most frequent behaviors cited were: "taking initiative, counseling, communicating, identifying problems, directing, organizing and persuading" (p. 5000-A).

Several theoretical frameworks have been used to study nursing leadership. Fiedler's (1967) Leader Contingency Model of Leader Effectiveness was used by Reilly (1970) and Fine (1978). The theories of the Ohio State University Studies focusing on Initiating Structure

and Consideration were used by Kelley (1970) in developing a tool to examine leadership behavior of nursing supervisors. Brock (1978) investigated a management concept course using Gross' (1968) Global Matrix Model. Situational Leadership Theory, however, is relatively new to nursing research literature.

Fine (1978) and Johnson (1976) used Situational Leadership Theory, along with other theories as a basis for their studies. Fine (1978) proposed that this theory be used as a guideline for determining appropriate leader behavior in nursing. Johnson (1976) concluded: "the greater the congruence between the leader's self-perception and the perceptions of the leaders by others, the greater the effectiveness of the leader" (p. vi).

Gray (1983) also used Situational Leadership Theory to examine leadership styles and adaptability of nursing team leaders. Interestingly, he found that a high task/high relationship leadership style was chosen most frequently by both team leaders and team members. He also suggested that the level of sophistication of tasks be considered when prescribing appropriate leadership styles for professional fields.

Ausen (1980) used Situational Leadership Theory to determine the leadership behaviors and style of 30 Emergency Department Head Nurses. She also examined the perceptions of the maturity level of the head nurses. Since Situational Leadership Theory contends that the effective leader adjusts his/her style based on the maturity level of the followers, it seems likely that in order for the leader to appropriately adjust his/her style and be an effective leader, the maturity level of the leader would need to be relatively high.

In summary, Situational Leadership Theory (Hersey and Blanchard, 1969) evolved from the earlier leadership theories of Taylor (1911), Mayo (1933), and McGregor (1960), among others. Hersey and Blanchard added the dimension of the situation and maturity level of the followers to the notion of leadership having task and relationship aspects. The effective leader, then, has the ability to adapt his/her leadership behavior to meet the needs of the situation and the followers; therefore, he/she has the capacity to exhibit all leadership styles.

Research on women as leaders has shown that the sex role socialization of our society may limit the types of leadership behavior that women learn. Thus, leadership approaches requiring low relationship behaviors are probably lacking in novice women leaders.

Many nursing leadership studies have focused on personality and trait theories, however, findings are inconsistent. The notion that nursing leadership can be studied using Situational Leadership Theory is relatively new (Johnson, 1976). This study and that of Ausen (1980) use this theory as a basis for describing nursing leadership among head nurses.

Chapter III

Methodology

Polit and Hungler (1983) suggest that replicating an earlier study is an appropriate way to test the generalizability of findings to other settings and samples. This chapter will describe how the methodology of this study replicated that of Ausen's (1980) study. A description of the population, sample, procedures used for data collection and method of data analysis is given.

Population and sample

Target population. Head nurses probably have less leadership experience prior to their promotion than any other nursing group in the hospital organization. Head nurses are leaders by the position they hold. Ausen (1980) studied the leader behavior of head nurses in emergency departments, a highly specialized service and dealing primarily with outpatients. In order to test the generalizability of her results to other head nurses, it seems appropriate to study leadership behaviors of head nurses in less specialized, in-patient units. Head nurses of medical-surgical units fit this criteria.

Sample. In order to control variables, the criteria for the sample of this study were similar to that in Ausen's (1980) study, eg., only head nurses employed by hospitals accredited by the Joint Commission of Accreditation of Hospitals (JCAH) and having 200 or more beds, were used. The population of accessible medical-surgical head nurses were within a 100 mile radius of Columbus, Ohio. Permission to conduct the study was granted by the Director of Nurses. Procedures of each

institution were followed.

The sample for this study included medical-surgical head nurses (MSHN's), their immediate supervisors and a minimum of three subordinates. The sample included 30 head nurses; no more than three from any one hospital to avoid a possible bias. The immediate supervisor represented the leader's superior. The exact number of supervisors was 27, as some functioned as the superior to more than one MSHN in the sample. The subordinates represented the followers. Randomization in selection was used whenever feasible on the day of data collection. For each MSHN (leader) then, there was a minimum of four "others" to provide perceptions of leader behavior.

Subjects selected for study met the following criteria; 1) the MSHN was a registered nurse, who agreed to participate and if possible was on duty on the designated day of data collection; 2) the MSHN supervisor and a minimum of three subordinates also agreed to participate in the study. Although Ausen (1980) surveyed some physicians in her study, they were not included in this study. This is due to the fact that physicians do not generally spend as much time working with MSHN's as emergency physicians spend working with emergency room head nurses and therefore, it was not perceived that they qualified as associates for this survey.

Procedures for data collection

Hospitals that met the criteria were selected at random. Initial contact was made by telephone to the director of nurses of each selected hospital. An explanation of the study, purpose and time required (approximately 30 minutes for each participant) was given. Each

participating nursing service was promised a written summary of the results. Following verbal agreement to participate, a letter followed to confirm agreement. Identification of subjects was accomplished through the nursing department of each hospital. The time of day allotted for subjects to complete the surveys was negotiated with the nursing department. When possible, all subjects from each hospital were to meet with the investigator simultaneously. However, this was possible only once. A return visit by the investigator was necessary in some cases. Subjects were informed of the purpose for the study. They were assured that their anonymity would be preserved, as the instruments were coded in such a manner that superiors and subordinates could be matched to MSHN's, however, only the investigator knew the coding system. Following data analysis the coding system was destroyed. An informed consent form (Appendix A) was signed by all who agreed to participate. The directions for completing each instrument was read by the subjects and questions answered by the investigator. Three tools were used to collect data; the Leader Effectiveness and Adaptability Description Instrument (LEAD-Self and LEAD-Other), the Head Nurse Maturity Scale, and Personal Inventory Tools.

The LEAD instruments were obtained from the Center for Leadership Studies, Escondido, Ca. and were developed by Hersey and Blanchard to measure Task and Relationship Behavior of leaders through the perceptions of self and others. The scores obtained were used to determine the leader's dominant leadership style, range of leadership styles and adaptability to various situations. The LEAD instrument, both Self and Other forms, has been widely used in management training programs

(Hersey and Blanchard, 1982).

Information concerning reliability and validity of the LEAD instrument was obtained from the Center for Leadership Studies and written by John F. Greene, Ph.D.

> The LEAD-Self was standardized on the responses of 264 managers constituting a North American sample. The managers ranged in age from 21 to 64; 30 percent were at the entry level of management; 55 percent were middle managers; 14 percent were at the high level of management...
>
> The stability of the LEAD-Self was moderately strong. In two administrations across a six-week interval, 75 percent of the managers maintained their dominant style and 71 percent maintained their alternate style. The contingency coefficients were both .71 and each was significant ($p<.01$)... The LEAD-Self scores remained relatively stable across time, and the user may rely upon the results as consistent measures.
>
> The logical validity of the scale was clearly established. Face validity was based upon a review of the items, and content validity emanated from the procedures employed to create the original set of items.
>
> Several empirical validity studies were conducted. As hypothesized, correlations with the demographic/organismic variables of sex, age, years of experience, degree and management level were generally low, indicating the relative independence of the scales with respect to these variables. Satisfactory results were reported supporting the four style dimensions of the scale using a modified approach to

factor structure. In 46 of the 48 item options (96 percent), the expected relationship was found. In another study, a significant ($p<.01$) correlation of .67 was found between the adaptability scores of the managers and the independent ratings of their supervisors. Based upon these findings, the LEAD-Self is deemed to be an empirically sound instrument.

An example of this tool is found as Appendix B.

Ausen (1980) adapted the Maturity Scale for followers developed by Hambleton, et al. (1977) to measure the maturity level of head nurses. This tool was designed to measure both Job Maturity and Psychological Maturity of the followers in performing specific responsibilities. Ausen (1980) adapted this scale by listing five priority responsibilities of head nurses as leaders. She developed this list by matching perceived responsibilities of head nurses as related to her by five assistant head nurses and two former head nurses with a Position Description for head nurses from a medical center in the midwest. The five resulting matched pairs were incorporated into the Maturity Scale. Ausen (1980) pilot tested the adapted Maturity Scale for head nurses with three head nurses. She reports that the "participants of the pilot test had no difficulty in understanding or applying the scale" (p. 45). Copies of the Maturity Scale were obtained from the Center for Leadership Studies, Escondido, Ca., and adapted as done by Ausen (1980). An example is found in Appendix C. The description of Major Objectives and Responsibilities of Head Nurses for Leader Maturity Scale (Appendix D) developed by Ausen (1980) was used in conjunction with the Maturity Scale.

Demographic data of age, sex, education and experiential background for the head nurses, superiors and subordinates (Appendices E, F, and G) were obtained with the Personal Inventory Tool developed by Ausen (1980).

Data analysis

Data collected included scores from either LEAD-Self or LEAD-Other, and either the Self or Other, Head Nurse Maturity Scale, and demographic information. Mean scores from these tests were used to: 1) describe the dominant leadership style of MSHN's; 2) describe the range of leadership styles available to the MSHN's; and, 3) describe the MSHN's Maturity Level.

Fisher's Exact Test of Probability was used to determine the degree of correlation between self-perception and other-perception of: 1) the MSHN's dominant leadership style; 2) the MSHN's range of leadership styles; 3) the MSHN's Maturity Level; 4) the MSHN's range of leadership styles and maturity level. Although Ausen (1980) used Phi and Chi-Square, many of the expected cells in this study were less than 5. Fisher's Exact Test, therefore, was deemed a more accurate measure of probability. A statistical test to compare the results of this study to the results found by Ausen (1980) is not appropriate without the raw data from her study. Therefore, the comparison will be presented in table format only.

Chapter IV

Findings

This chapter will present the findings of this study. The demographic findings will be discussed first, followed by a description of the findings for each of the eight hypotheses.

Demographic findings

A total of 30 MSHN's representing 11 hospitals in Central Ohio, participated in this study. Demographic data was obtained from the Personal Inventory Tool. The MSHN's ranged in age from 25 to 58 with a mean age of 36.6. The average period that each MSHN had held her current position was six years with the time ranging from less than one year to 18 years. The entire sample of MSHN's were female. The basic nursing preparation fro 19 of the MSHN's was a diploma program. Six graduated from an associate degree program and five from a baccalaureate. All of the MSHN's had graduated from their basic program between 1945 and 1980. The majority (n=19) had received no academic credit hours beyond their initial degree and of those who had, the average number of credit hours earned was 8. Four MSHN's had received a baccalaureate degree beyond their basic nursing preparation, but only one had received her degree in nursing. The other degrees were in business administration, mathematics, and education. None of the MSHN's had earned a master's degree, but one did expect to in 1984. Twenty-six of the 30 MSHN's stated that they had received some leadership training, either through the hospital in which they worked or as continuing education. In their position as head nurse, each MSHN had a certain number of subordinates,

on an average they claimed 12.5 full time RN's, 6.3 part-time RN's, 3.8 full time LPN's, 2.4 part-time LPN's, 4.8 full time aides, 2.3 part-time aides, 1.2 full time "others" and 1.4 part-time "others". Nine of the MSHN's stated that their units delivered secondary care, four claimed primary care and one tertiary care. The remainder stated that a combination was given on their units and eight stated that all three types of care was given on their units.

The superiors to the MSHN's were also asked to complete the Personal Inventory Tool. Twenty-one superiors supervising the 30 MSHN's participated. The fewer number of superiors indicates that some superiors supervised more than one MSHN in the study. The superiors ranged in age from 27 to 60 with an average age of 42. They had been appointed to their present position sometime between 1965 and 1983. All but one of the superiors was female. Basic nursing preparation for 19 of the superiors was from a diploma program; one from a baccalaureate and one claimed a master's program as basic preparation. All had graduated between 1941 and 1978. Most of the superiors (n=13) had not received additional academic credits since their graduation from their basic program. However, eight had received an average of 15.5 additional credit hours. Three of the superiors had received a baccalaureate degree after their basic preparation, however only one was in nursing. The others were in business administration and psychology. Five of the superiors expected to receive additional degrees sometime between 1984 and 1990. Two of the superiors had received subsequent master's degrees, one in 1979 and one in 1980. Fifteen of the superiors reported receiving some type of leadership training. Many of them reported multiple courses.

In their position as superior to the MSHN's, the superiors reported having many subordinates. They claimed an average of 21.4 full time RN's, and 8.5 part-time RN's working for them. They also claimed an average of 4.6 full time LPN's, 1.4 part-time LPN's, 12.7 full time aides, 4.7 part-time aides, 2.2 full time "others", and 1.0 part-time "others", working directly for them.

Ninety subordinates of the 30 MSHN's participated in this study. They ranged in age from 21 to 59 with an average age of 33. They had all been appointed to their present position sometime between 1954 and 1983, with an average having worked in their present position since 1977. Only one of the subordinates in this study was male.

Fourteen hospitals fitting the criteria were contacted to participate in the study, three declined. Of the eleven participating all but two provided three MSHN's and the required others. One hospital could only provide two MSHN's, consequently the 11th hospital was requested to only provide one MSHN with her required others.

The remainder of the findings of this study will be presented in order of hypotheses.

Hypothesis one

"The dominant leadership style of head nurses as both self and other perceived is High Task/High Relationship (HT/HR)". The leadership style of head nurses was determined by administering the LEAD-Self to the MSHN's and the LEAD-Other instruments to the superiors and subordinates. Table 1 shows the results based on these two instruments. Dominant style was determined to be that style which was chosen at least six times out of the 12 situations given. The dominant leadership style as

Table 1
Dominant Leadership Style

Respondents		HT/LR	HT/HR	LT/HR	LT/LR	HT/LR & HT/HR	HT/HR & LT/HR	No Dominance
Self	%		63%	10%				27%
	n		19	3				8
Others								
Superiors	%	3%	37%	17%		3%		40%
	n	1	11	5		1		12
Subordinates	%	9%	53%	5%	3%		3%	26%
	n	8	47	4	3		3	23
Combined others	%	8%	49%	8%	3%	1%	3%	30%
	n	9	58	9	3	1	3	35

self-perceived by 63% of the head nurses was HT/HR. A total of 73% (n=22) saw themselves as having a high relationship dominant leadership style. Twenty-seven percent of the head nurses saw themselves as having no dominant leadership style.

Of the superiors and subordinates combined, 49% perceived the head nurse as having a dominant HT/HR leadership style. Those who perceived the head nurse as having some type of high relationship style totalled 71 (60%). Thirty percent perceived none of the leadership styles as dominant. The perceptions of the MSHN's and the others show some consistency in selecting HT/HR style as dominant and the hypothesis is therefore supported.

Hypothesis two

"There is a high degree of correlation between self-perception and other-perception of the dominant leadership style of head nurses."

The data in Table 2 shows the frequency and percentage of the self rated dominant leadership style of the MSHN's compared with the frequency and percentage of the dominant leadership style as rated by their others. The most consistent agreement was with the HT/HR style. Forty-four percent (n=33) of the others agreed with the 63% of the self-ratings of the MSHN's on that particular leadership style. Another 31% rated these MSHN's as having no type of leadership style as dominant.

Agreement between MSHN's and their others on HT/HR style as dominant was statistically significant, using Fisher's Exact Test ($p=.006$). Significance was determined to be $\leq .05$. The next highest area of agreement between MSHN's and other's perceptions occurred in the category of no dominant leadership style. However, this agreement

Table 2

Frequency and Percentage of Self-rated Dominant Leadership Styles of MSHN's Compared with Frequency and Percentage of Other-rated Dominant Leadership Styles

Dominant Leadership Style--Others	Others		Dominant Leadership Style--Self*							
			HT/HR		LT/HR		No dominance		Total	
Style	n	%	n	%	n	%	n	%	n	%
HT/LR	8	7%	7	11%	0	0	1	3%		
HT/HR	58	49%	33	44%	8	67%	17	55%		
LT/HR	9	8%	5	7%	1	8%	3	10%		
LT/LR	3	3%	3	4%	0	0	0	0		
HT/LR & HT/HR	1	1%	1	1%	0	0	0	0		
HT/HR & LT/HR	3	3%	2	3%	0	0	1	3%		
No dominance	35	30%	23	31%	3	25%	9	29%		
Total	118	100%	75	64%	12	10%	31	26%	30	100%

*No MSHN's perceived themselves as having HT/LR or LT/LR leadership styles as dominant, therefore these columns were not included on this table.

was not statistically significant (p=.576).

In summation, then, a high degree of correlation (agreement) between the self-perception of the MSHN's and the perceptions of their others did exist among those who selected HT/HR as a dominant leadership style. This is consistent with the findings for Hypothesis one and Hypothesis two is therefore supported.

Hypothesis three

"The range of leadership styles exhibited by head nurses, as both self and other perceived, includes all four of the leadership styles described in Situational Leadership Theory (Hersey and Blanchard, 1982)".

This hypothesis was tested by the sample's responses to the 12 situations in the LEAD instruments. In order to accurately describe the range of leadership styles represented, the strength of each style is also presented. Table 3 shows the range of leadership styles perceived by the MSHN's and the others. Table 4 shows the mean scores for each group in the sample as well as the percentage for each style.

According to the figures in Table 3, MSHN's described themselves as having a range of 2,3 or 4 leadership styles and the others, for the most part, agree. One subordinate perceived her head nurse as having only one leadership style.

Table 4 shows the strength of each leadership style by presenting the mean score of leadership style. This score represents the number of times that particular style was perceived in response to the 12 situations given. The strongest style selected by the MSHN's was HT/HR and the weakest style was LT/LR. This is consistent with the strengths found by both the superiors and subordinates.

Table 3

Range of Leadership Styles Perceived by the MSHN's and the Others

Respondents		1 Style	2 Styles	3 Styles	4 Styles
Self	%	0	7%	57%	37%
	n	0	2	17	11
Others					
Superiors	%	0	17%	43%	40%
	n	0	5	13	12
Subordinates	%	1%	18%	49%	32%
	n	1	16	43	28
Combined	%	1%	18%	47%	34%
	n	1	21	56	40
Total	%	1%	16%	49%	34%
	n	1	23	73	51

Table 4

Mean Score and Percentage for each Leadership Style by Group

Respondent Groups	value	Leadership Styles HT/LR	HT/HR	LT/HR	LT/LR
Self	$\bar{x}$*	1.7	6.13	3.36	.8
	SE	.21	.345	.316	.169
	%	14%	51%	28%	7%
Superior	$\bar{x}$	2.6	4.7	3.5	1.1
	SE	.36	.44	.412	.266
	%	22%	39%	29%	9%
Subordinates	$\bar{x}$	2.3	5.7	3.1	.8
	SE	.244	.231	.189	.157
	%	19%	48%	26%	7%
Others Combined	$\bar{x}$	1.89	4.3	2.55	.698
	SE	.218	.226	.195	.147
	%	20%	46%	27%	7%

*$\bar{x}$ = the number of times that style was perceived in response to the 12 situations given (average)

Although many MSHN's and others in the sample perceived the head nurse as having all four leadership styles, the largest percentage perceived only three styles in the total range of four. This hypothesis, therefore, cannot be totally supported. The mean scores and percentages of each style as displayed in Table 4, shows HT/HR style as the strongest; again being consistent with the findings of Hypothesis one.

Hypothesis four

"There is a high degree of correlation between self-perceived and other-perceived range of leadership styles of the head nurse."

In order to test this hypothesis, responses on the LEAD-Self and LEAD-Other were again used and responses were categorized according to style strengths. The possible strengths were 0 to 12. The higher the score, the higher the strength. The scores were arranged into strength groups. The lowest score or strength from 0 to 2, moderate score/ strength from 3 to 5, and the highest score/strength 6 or above. Table 5 shows the percentages of style strength ratings for each of the four leadership styles as given by both self and others. In the HT/LR style, 83% (n-25) of the head nurses rated themselves 0-2, 61% of the others agreed. In the HT/HR style 63% of the head nurses rated themselves 6 or above, while 53% of the others agreed. The highest percentages for the LT/HR style fell in the 3-5 strength category with 57% of the self-ratings and 53% of the other-ratings. One hundred percent of the MSHN's rated themselves in the 0-2 range for the LT/LR style, while 89% of the others agreed.

The most variable leadership style was LT/HR with 10%-57% of the MSHN's rating themselves from 0-12. The others agreed with 9% to 53%

Table 5

Percentage of Style Strength Ratings for each of the Four Leadership Styles by Score on LEAD instruments

Respondents & Style Strength Range	Leadership Styles			
	HT/LR	HT/HR	LT/HR	LT/LR
Self 0-2	83%	0	33%	100%
Others 0-2	61%	12%	38%	89%
Self 3-5	17%	37%	57%	0
Others 3-5	31%	36%	53%	8%
Self ≥6	0	63%	10%	0
Others ≥6	8%	53%	9%	3%

rating the same way. The least variable style was the LT/LR style. The commonest leadership styles are those that present the strongest scores, while the weakest styles are those that present the weakest scores. The HT/HR was found to be the most common leadership style and the LT/LR style the least common in this sample.

The correlation of agreement between the range of leadership styles determined by self and others was p=.347, indicating a non-significant agreement. Agreement between self and others scores on strength ranges were statistically significant for the low range (0-2) scores of the LT/LR style (p=.007) and for the low range (0-2) score of the HT/LR style (p=.008). None of the other agreement correlations were significant including the high score ($\geq$6) range of HT/HR (p=.195). Table 6 indicates the percentage of other perceptions which matched the MSHN's self-perceptions in the style strength ranges. Fifty-two percent of the others agree with their MSHN's that HT/LR leadership is very weak, if perceived at all and 97% of the others agree with the MSHN's self-perceptions on the weakest of their LT/LR leadership strengths. It is interesting to note that both of the weakest styles seen by the entire sample are low relationship.

Hypothesis five

"The maturity levels of head nurses as perceived by self and others is high."

Maturity in this study was subdivided into Job Maturity and Psychological Maturity. Job Maturity, as defined earlier, is the individual's ability or competence to perform a task; the individual has the knowledge, ability and experience to do the task without direction

Table 6

Percentage of Other-perceptions which Match Self-perceptions of MSHN's in Style Strength Ranges

Style Strength Range	Leadership Styles			
	HT/LR	HT/HR	LT/HR	LT/LR
0-2	52%	0	15%	97%
3-5	6%	13%	30%	0
6-12	0	31%	1%	0
	58%	44%	46%	97%

from others (Hambleton, et al., 1977, p. 4). On the other hand, Psychological Maturity is the individual's willingness or motivation to perform a task; the individual believes his or her responsibility for the task is important and has self-confidence and good feelings about him or herself; the individual does not need "psychological strokes" or encouragement to do the job (Hambleton, et al., 1977, p. 4). Tables 7-11 show the mean scores and standard error for Job Maturity and Psychological Maturity in each of the major objectives and for each category of respondent (self, superior and subordinate).

The possible range of scores for job and psychological maturity is from 5 to 40. A range from 33-40 is considered by Hersey and Blanchard (Maturity Scale) to be high; a range from 13 to 32 as moderate and 5 to 12 as low. The overall average scores for both job and psychological maturity in this entire sample ranged from 32.5 to 36.2 falling primarily in the high maturity range. The standard errors are for the most part less than one, indicating relatively similar responses in all categories by all respondents. The head nurses consistently see themselves as more mature in objectives one, three, four and five than either their superiors or subordinates see them. For example, head nurses perceive themselves to be more able and willing to participate in and oversee the care given to patients, to provide leadership, develop and renew plans for the operation of the unit, and develop their own competencies (Objectives 1,3,4,5), than either their superiors or subordinates perceive them. The only area in which the subordinates perceived the head nurses as more mature than they saw themselves was in job maturity for objective two; subordinates perceived MSHN's more

Table 7

Mean and Standard Error of Job Maturity and Psychological Maturity for Objective One* as Perceived by Self, Superiors and Subordinates

Respondents		Job Maturity	Psychological Maturity
Self	$\bar{x}$	35.4	36.2
	SE	.571	.433
Superiors	$\bar{x}$	34.5	34.8
	SE	.735	.912
Subordinates	$\bar{x}$	34.5	34.2
	SE	.459	.682

*Objective One = Participates in and oversees the care given to patients

Table 8

Mean and Standard Error of Job Maturity and Psychological Maturity for Objective Two* as Perceived by Self, Superiors and Subordinates

Respondents		Job Maturity	Psychological Maturity
Self	$\bar{x}$	33.7	34.8
	SE	.814	.629
Superiors	$\bar{x}$	33.4	34.0
	SE	.731	.891
Subordinates	$\bar{x}$	33.9	33.7
	SE	.480	.654

*Objective Two = Facilitates intra- and interdisciplinary team functioning

Table 9

Mean and Standard Error of Job Maturity and Psychological Maturity for Objective Three* as Perceived by Self, Superiors and Subordinates

Respondents		Job Maturity	Psychological Maturity
Self	$\bar{x}$	34.3	36.2
	SE	.832	.492
Superiors	$\bar{x}$	32.5	34.2
	SE	.864	.871
Subordinates	$\bar{x}$	33.0	33.7
	SE	.534	.625

*Objective Three = Provides leadership which stimulates self-growth and satisfaction

Table 10

Mean and Standard Error of Job Maturity and Psychological Maturity for Objective Four* as Perceived by Self, Superiors and Subordinates

Respondents		Job Maturity	Psychological Maturity
Self	$\bar{x}$	35.5	35.7
	SE	.639	.702
Superiors	$\bar{x}$	33.3	34.9
	SE	.816	.847
Subordinates	$\bar{x}$	34.7	34.4
	SE	.522	.607

*Objective Four = Develops and renews the plans for operation of the unit

Table 11

Mean and Standard Error of Job Maturity and Psychological Maturity for Objective Five* as Perceived by Self, Superiors and Subordinates

Respondents		Job Maturity	Psychological Maturity
Self	$\bar{x}$	35.6	35.5
	SE	.709	.673
Superiors	$\bar{x}$	33.0	34.0
	SE	.940	1.102
Subordinates	$\bar{x}$	34.1	34.4
	SE	.578	.650

*Objective Five = Develops own competence in nursing and related areas

able to facilitate team functioning than MSHN's perceived themselves.

Table 12 displays the Total Maturity as measured by the Maturity Scale. Maturity level one is low maturity, meaning the MSHN lacks both willingness and ability to carry out the objective or responsibility. Maturity levels two and three are moderate maturity levels. Hersey and Blanchard (1982) claim that Maturity level two indicates that one is willing or confident but unable to do the task. Maturity level three reflects ability but unwillingness or insecurity. The highest maturity level is four and indicates that the MSHN has both the willingness and ability. The figures on Table 12 show that the average maturity score from all respondents was 6.1 to 6.8, falling within the moderately high maturity level. This hypothesis is therefore supported by the data. MSHN's were perceived in this study to have both the ability and willingness to perform their responsibilities.

Hypothesis six

"There is a high degree of correlation between the self-perceived and other-perceived Maturity Levels of head nurses."

A comparison was made between the self maturity scores of the MSHN's and the maturity scores given them by their others. Table 13 shows the Job Maturity and Psychological Maturity scores of the MSHN's and the percentage of their others who agreed with them. Scores and percentages are given for each of the five objectives. There is a relatively high percentage of agreement on scores ranging from 33-40 on both Job Maturity and Psychological Maturity for all five objectives. Significant agreement was displayed in several areas. For scores ranging between 23-32, a low probability of the scores resulting from chance

Table 12

Means[+] of Total Maturity Indices of MSHN's for each Objective as Rated by Self and Others

Respondents	Objectives[*]				
	1	2	3	4	5
Self	6.8	6.5	6.3	6.6	6.5
Superiors	6.5	6.2	6.1	6.3	6.2
Subordinates	6.3	6.2	6.2	6.3	6.2

[+]Means are computed based on the following equivalencies:

1 = M1
2 = M1/2
3 = M2
4 = M2/3
5 = M3
6 = M3/4
7 = M4

[*]Objective numbers correspond to the following numbers as found in Appendix D

1 = Participates in and oversees the care given to patients
2 = Facilitates intra- and interdisciplinary team functioning
3 = Provides leadership which stimulates self-growth and satisfaction
4 = Develops and renews the plans for operation of the unit
5 = Develops own competence in nursing and related areas

Table 13

Percentage of Agreement between Self-perceived and Other-perceived Job and Psychological Maturity Levels

Respondents	Objectives*									
	1		2		3		4		5	
	JM†	PM	JM	PM	JM	PM	JM	PM	JM	PM
Self 13-22			3%		3%					
Others 13-22			0		0					
Self 23-32	17%	7%	23%	20%	37%	13%	27%	13%	20%	27%
Others 23-32	35%	75%	54%	33%	48%	25%	56%	44%	42%	19%
Self 33-40	83%	93%	73%	80%	60%	87%	73%	87%	80%	73%
Others 33-40	73%	75%	70%	66%	79%	61%	74%	76%	65%	68%

+JM = Job Maturity: PM = Psychological Maturity

*Objective numbers correspond with the following objective as found in Appendix D.

1 = Participates in and oversees the core given to patients

2 = Facilitates intra- and interdisciplinary team functioning

3 = Provides leadership which stimulates self-growth and satisfaction

4 = Develops and renews the plans for operation of the unit

5 = Develops own competence in nursing and related areas

(p .05) was found for Job Maturity in Objective two (p = .007) and three (p = .001). Low probability was also found for scores ranging between 33-40 for Job Maturity in Objective three (p = .009). No other statistically significant correlations were found in either Job or Psychological Maturity scores.

Table 14 shows the percentage of agreement between MSHN's and their other's on Total Maturity of the MSHN's. Significant agreement was found in only two areas, the M3/4 score for Objective four (p = .002) and the M4 score for Objective five (p = .009).

Since the majority of scores on Job Maturity, Psychological Maturity and Total Maturity are not statistically significant in agreement, the hypothesis cannot by supported.

Hypothesis seven

"There is a low degree of correlation between the dominant leadership style of head nurses and their Maturity Level as perceived by themselves and others."

According to Situational Leadership Theory, leadership styles should be matched to the followers maturity level (Hersey and Blanchard, 1982, p. 154). A HT/LR style should be used with an M1 maturity level; a HT/HR style should be used with an M2 maturity level, a LT/HR style should be used with an M3 maturity level and a LT/LR style should be used with an M4 maturity level. In describing the leadership styles of MSHN's, however, does the maturity level of the MSHN's match the dominant leadership style that the MSHN displays? If this were the case, those MSHN's whose dominant leadership style was HT/HR would have a maturity level of M2. Those with a dominant leadership style of LT/HR

Table 14

Percentage of Agreement between Self-perceived and Other-perceived Total Maturity Levels

Respondents	Objectives*				
	1	2	3	4	5
Self M2/3		3%	3%		
Others M2/3		0	0		
Self M3	3%	13%	7%	13%	17%
Others M3	100%	38%	13%	44%	20%
Self M3/4	17%	13%	33%	13%	13%
Others M3/4	20%	6%	15%	44%	19%
Self M4	80%	70%	57%	73%	70%
Others M4	63%	60%	64%	68%	61%

*Objective numbers correspond to the following Objective numbers as found in Appendix D

1 = Participates in and oversees the care given to patients
2 = Facilitates intra- and interdisciplinary team functioning
3 = Provides leadership which stimulates self-growth and satisfaction
4 = Develops and renews the plans for operation of the unit
5 = Develops own competence in nursing and related areas

would have a maturity level of M3, etc. As shown in Table 15, none of the MSHN's perceived a match between their dominant leadership style and maturity level. Likewise, only four of the "others" perceived a match. Correlation of these two variables in this sample is very low to non-existent, thereby supporting the hypothesis.

Hypothesis eight

"There is a high degree of correlation between maturity level and range of leadership styles of head nurses."

This hypothesis logically follows hypothesis seven. If there is no relationship between dominant leadership style and maturity level, perhaps there is a relationship when range of leadership styles and maturity level are compared. For example, those MSHN's perceived to have only one style would have an M1 maturity level, those with two styles would have an M2 maturity level, etc. Table 16 displays the number in the sample who perceived the MSHN as having one, two, three or four styles and the number of those who perceived a match in maturity level. For example, of the 11 MSHN's who perceived themselves demonstrating four leadership styles, nine of them perceived their overall maturity level as M4.

The correlational agreement between range of leadership styles and maturity level was found to be significant for self-perceptions of MSHN's ($p = .001$) and the perceptions of their subordinates ($p = .002$). The agreement between these variables for the perception of the superiors, however, was not significant ($p = .136$). The hypothesis, then, cannot be supported. Agreement between range of leadership styles and maturity level seems to be dependent upon one's point of view.

Table 15

Comparison of Dominant Leadership Style and Maturity Level

Respondents		Leadership Styles/Total Average Maturity							
		HT/LR	M1	HT/HR	M2	LT/HR	M3	LT/LR	M4
Self	%			63%	0	10%	0		
	n			19		3			
Others									
Superiors									
	%	3%	0	37%	0	17%	40%		
	n	1		11		5	2		
Subordinates									
	%	9%	0	53%	0	5%	0	3%	33%
	n	8		47		4		3	1

Table 16

Comparison of MSHN's Range of Leadership Style and Mean Total Maturity Score

Respondents	1 Style	M1	2 Styles	M2	3 Styles	M3	4Styles	M4
Self	0	0	2	0	17	3	11	9
Others								
Superiors	0	0	5	0	13	1	12	4
Subordinates	1	0	16	0	43	9	28	16
Combined others	1	0	21	0	56	10	40	20

Chapter V

Summary, Discussion and Implications

This study was conducted in order to replicate Ausen's (1980) study to describe the leader behavior of head nurses. This chapter will provide a summary of this study and describe some of the limitations, significance of the findings and implications for future research and practice.

Summary

Using the theory of Situational Leadership by Hersey and Blanchard (1982) this study was conducted to describe leader behaviors of MSHN's in central Ohio. It is a replication of a study by Ausen (1980), who described the leader behaviors of Emergency Department Head Nurses in Virginia. According to Situational Leadership Theory, there are four types of leader behavior: High Task/Low Relationship, High Task/High Relationship, Low Task/High Relationship, and Low Task/Low Relationship. The effective leader is capable of using all four styles and will select the appropriate one based on the situation and the maturity of the followers. This present study investigated which of these styles MSHN's use and which are used predominantly (if any). The study was conducted by collecting data from three groups of people using three instruments. The groups of people included 30 MSHN's, as well as one superior and three subordinates for each. The data collecting instruments used were the LEAD (Self and Other), the Head Nurse Maturity Scale (adapted from the Maturity Scale by Hambleton, et al., 1977) and a Personal Inventory Tool.

Eight hypotheses (derived from the findings of Ausen's 1980 study) were tested. Findings revealed that the sample of MSHN's were all female and were predominantly graduates of a diploma school program. They displayed a dominant leadership style of HT/HR as perceived by both self and others (all findings were based on the perceptions of self and others). A high degree of correlation existed between the perceptions of the MSHN's and their others, concerning the HT/HR style as dominant. Some perceived the MSHN's to display all four types of leadership styles to some degree, but the largest percentage perceived the MSHN's to display only three of the four styles possible. There was no significant agreement between the MSHN's and their others on the range of leadership styles used by MSHN's. However, there was significant agreement between the MSHN's and their others on both of the low relationship styles being rarely displayed.

Maturity level of the MSHN's was also studied to determine if there was any relationship between the maturity of the MSHN's and the dominant leadership style or range of styles which they chose to use. The average maturity score for all the MSHN's fell within the moderately high maturity level. Although there was some significant agreement between the MSHN's and their others on certain maturity levels for certain objectives (ie., for M3/4 score on developing and renewing the plans for operation of the unit), the vast majority of MSHN's perceptions and the others perceptions did not agree significantly on maturity levels. In addition, there was no correlation between the dominant leadership style of MSHN's and their perceived maturity level. There was, however, some significant agreement

between the self-perceptions of the MSHN's and the perceptions of their subordinates when the range of leadership styles and maturity level were correlated. This did not hold true for the superiors. Therefore, the general statement that there is a correlation between range of leadership styles and maturity level could not be supported.

Limitations

One of the major limitations was found in selecting the sample. Selection of MSHN's within each hospital was not always done on a random basis. Although the participating hospitals were randomly selected from those meeting the criteria, the members of the nursing staff were usually selected by the nursing administration of the hospital. This was due to the investigators unfamiliarity with the nursing staff, schedules and workload.

Another limitation was in collecting the data. The methodology called for administering the LEAD-Self/LEAD-Other and Maturity Scale. These are pencil and paper tests, requiring the judgment of the persons in the sample. Although individual subjective biases were adjusted for by requiring five viewpoints for each MSHN, one cannot be certain that the adjustment for subjective bias was actually made.

Another limitation involving methodology involved the actual answers one gave to the LEAD-Self and LEAD-Other situations. Although explicit instructions were given to answer the situations based on perceptions of head nurse behavior, assurance that the respondents did not answer the situations the way they thought they should be handled versus the way they actually are handled by the head nurse cannot be made. The lack of significant correlation of perceptions between MSHN's and their others

may have been due in part to this phenomenon.

Collection of the data required longer than the two week period initially allotted. Because of workload, many respondents could not complete the instruments on the assigned day, requiring a return visit by the investigator. All of the data collection was done on a face-to-face basis in order to give instructions and answer questions, as well as to insure 100% return of instruments. It was seldom possible to meet with all participants from one facility at the same time. Consequently, some participants did not have the benefit of hearing questions and answers from other participants. In spite of the effort to make the instructions clear and understandable, three participants (all subordinates) failed to complete either the LEAD-Other or the Maturity Scale. This may have been the result of failing to understand and too embarrassed to ask questions in front of peers.

Another limitation was the sample size. In order to validly replicate Ausen's (1980) study the same number (30) of head nurses were included. Kerlinger (1973) contends that "whenever a mean, percentage, or other statistic is calculated from a sample, a plpulation is being estimated" (p. 127). Thus, the larger the sample the more generalizable the results.

A final limitation, perceived by this investigator, was the all-female MSHN sample. This would lead one to question the accuracy of a description of the leadership styles of head nurses. Are the results truly a reflection of nursing or are they really a reflection of women? It will be noted that Ausen (1980) and Bryant (1983) used all female samples and had similar results to the findings of this study. It will

also be noted that Ausen (1980) studied nurses, while Bryant (1983) studied teachers.

Significance of findings

The significance of studying the leadership styles of head nurses is based on the assumption that leadership behaviors are learned behaviors, not inherited traits (Hersey and Blanchard, 1982). Maturity, likewise, is a learned quality. The position of head nurse is the first level of the nursing leadership hierarchy in an organization. Head nurses, by virtue of their position, therefore, are leaders. Many nurses are promoted to this position because of their outstanding performance as staff nurses and usually without the benefit of effective leadership training. Head nurses, then, often learn these behaviors from those who have led them. This informal and haphazard leadership training may or may not be adequate. If a head nurse is to be a truly effective leader, s/he must have the capacity to adapt his/her leadership style to the situation and therefore must have a full range of leadership styles to choose from. One of the significant findings of this study was the perceived (both Self and Other) lack/weakness of low relationship leadership styles. This finding indicates a weakness in the full range of leadership behaviors available to head nurses.

By comparing the results of this study to those of Ausen (1980), as shown in Table 17, one can see that head nurses in different clinical settings demonstrate a similar ability to vary their leadership style in response to situational changes. For example, the head nurses in both studies showed some degree of all four leadership style (although there was very little of the low relationship styles shown). Head nurses in

Table 17

A Comparison of Results with those of Ausen's (1980) Study

Variables		Ausen's Results	Present Results
Dominant leadership style of head nurses		HT/HR	HT/HR
Degree of correlation between self and others perceptions of dominant leadership style		Significant	Significant
Range of leadership styles of head nurses			
1 style		Range of total sample included all 4 styles	1%
2 styles			16%
3 styles			49%
4 styles			34%
Degree of correlation between self and other perceptions of leadership style range		Not significant	Not significant
Maturity level:	Self	M3/4-M4	M3/4-M4
	Superiors	M3	M3/4-M4
	Subordinates	M3/4-M4	M3/4-M4
Degree of correlation between self and other perception of maturity level		Significant	Not significant
Degree of correlation between dominant leadership style and maturity level		Self- not significant Others- significant	All- not significant

both studies also showed a dominant leadership style of HT/HR with significant agreement between the perceptions of self and others. In addition, head nurses displayed a moderately high level of maturity in both studies (M3, M3/4, M4). Hersey and Blanchard (1982) would interpret this finding as reflecting ability with some degree of unwillingness or insecurity in doing the job. These findings have significant implications for nursing administration to develop the leadership and maturity levels of head nurses. If head nurses have a limited range of leadership styles they will be less effective in working with a wide range of personnel who, in turn, may become so dissatisfied with their jobs that they terminate employment (Leininger, 1974).

Implications for future research

Several areas for future research were discovered during the process of this investigation. A question was raised concerning the accuracy of the findings for male head nurses. Perhaps their leadership styles differ from female head nurses. If so, then the description of leadership among head nurses as presented here reflects only female head nurses.

Since so many of the head nurses in this study reported having had leadership training, but are somewhat weak in portraying low relationship behaviors, it may be appropriate to study how one effectively learns leadership behaviors. Perhaps the current leadership training is ineffective because it is not supported in practice by the head nurses' role models. Another study might investigate the effect of role models and mentors on head nurses leadership behaviors. Perhaps leadership training should be directed toward the top of the nursing

hierarchy in order that those individuals can become better role models and mentors.

Demonstration of head nurses' leadership behavior may be a result of the amount of autonomy they perceive that they have within the nursing department. A study of head nurses' leadership behaviors in centralized environments could be compared with the leadership behaviors in decentralized environments.

One dimension of maturity that was not investigated by this study was the maturity level of the followers (subordinates). According to Hersey and Blanchard (1982), in order to be effective, the leader must adapt his/her leadership style to the maturity of the followers. It is possible that the MSHN's in this sample were doing just that and their leadership styles then, were reflective of the maturity level of their followers (subordinates). Further study could answer this question by testing the Maturity Levels of both the head nurses and their followers.

Hersey and Blanchard (1982) believe that self-respect and self-confidence influence maturity levels. Further research could investigate these attributes in head nurses, as well as their superiors, to determine how they influence leadership styles and maturity levels.

These studies could result in a realistic approach to increasing the effectiveness of nursing leadership.

Implications for nursing community

In order for head nurses to increase their range of leadership styles they may need more effective leadership training and support from nursing administration. The results of this study and that of Ausen's (1980) indicate in which leadership areas head nurses show

definite weakness and, consequently, upon which areas leadership training should focus; ie., low relationship styles.

It may be advantageous to promote those nurses to leadership positions who have demonstrated a flexibility in leadership styles as staff nurses. Supervisors should be encouraged to support a flexibility in styles and foster, by example, the growth of those styles in which head nurses are the weakest. An indirect effect of increasing leadership style repertoire could be increased willingness and security in performing the duties of head nurse and consequently increase job satisfaction for nurses and decrease the turnover rate for hospitals (Leininger, 1974).

Nursing educators also have responsibility for developing leadership among nurses. Many nursing programs have traditionally emphasized high relationship behaviors (particularly between nurse and client) and then expect nurses to transfer those skills to the management of nursing staff. This tradition may be limiting the ability of nurses to effectively lead. More emphasis should be placed within nursing curricula to foster the full range of leadership styles. Nurses should learn to use and accept low relationship styles without becoming professionally devastated. This is particularly important as hospitals turn to all professional nursing staffs. In order for nurses to mature and develop they must be delegated increased responsibility that stems from a strong supportive system. Nurses cannot learn how to delegate or be delegated to unless they know how to be self-directed and deal effectively with low task/low relationship behaviors among themselves.

The literature is filled with pleas for well-prepared nurses leaders. This study and Ausen's (1980), describe the current status of leadership

in nursing, at the head nurse level. These findings can serve as a starting point for nursing educators and administrators to realistically develop those nurse leaders so urgently needed.

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APPENDIX A

Informed Consent Form

Informed Consent Form

I agree to participate in a study on leader behavior being conducted by Diana Kupchella, a graduate student in the School of Nursing at the Ohio State University. I understand 1) that participation in this study is voluntary, 2) that the information I provide will remain confidential, and 3) that I will not be identified by name. I further understand that the results of this study will not be used to rate the performance of the head nurse but rather, the results will be used to describe the leader behavior and maturity of the head nurse.

_____ _____

Date Participant's Signature

APPENDIX B

Leader Effectiveness and Adaptability Description

LEAD-Self

&

LEAD-Other

LEAD-Self

Directions:

Assume YOU are involved in each of the following twelve situations. Each situation has four alternative actions which you might initiate. Read each item carefully. Think about what you would do in each circumstance. Then circle the letter of the alternative action choice which you think would describe your behavior in the situation presented. Circle only one choice.

Example:

Situation:

"Your subordinates, usually able to take responsibility, are not responding to your recent redefining of standards."

Alternative Actions:

A. Allow group involvement in redefining standards, but don't take control.

B. Redefine standards and supervise closely.

C. Avoid confrontation by not applying pressure; leave situation alone.

D. Incorporate group recommendations, but see that new standards are met.

Copies of the LEAD instrument available through the Learning Resources Corporation

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LEAD-Other

Directions:

Assume (Name of the Leader) is involved in each of the twelve situations. Each situation has four alternative actions this leader might initiate. Read each item carefully. Think about what this person would do in each circumstance. Then circle the letter of the alternative action choice which you think would most carefully describe the behavior of this leader in the situation presented, based upon your experience with him/her. Circle only one choice.

Example:

Situation:	Alternative Actions: This leader would:
Subordinates, usually able to take responsibility, are not responding to the leader's recent redefining of standards.	A. allow group involvement in redefining standards, but would not take control. B. redefine standards and supervise carefully. C. avoid confrontation by not applying pressure; leave situation alone. D. incorporate group recommendations, but see that new standards are met.

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APPENDIX C

Head Nurse Maturity Scale

Head Nurse Maturity Scale

Explanation for the head nurse:

The purpose of this rating form is to help you, the head nurse to determine your own maturity. Maturity refers to the willingness and ability of a person to direct his or her behavior while working on a particular objective or responsibility. Willingness and ability are referred to as psychological maturity and job maturity, respectively.

Since your maturity level will depend upon the particular objective, your task will be to provide perceptions of your maturity in performing each objective.

Before completing the rating form, it is essential for you to reflect on your past performance in reference to quality of work output and attitudes as a head nurse. Think of specific projects and times on those projects when you were extremely pleased or displeased with yourself. Also, think how you typically think about yourself in terms of accomplishing each objective.

Explanation for the Others:

The purpose of this rating form is to help you determine the maturity of the head nurse with whom you work. Maturity refers to the willingness and ability of a person to direct his or her behavior while working on a particular objective or responsibility. Willingness and ability are referred to as psychological maturity and job maturity, respectively.

Since a person's maturity level will depend upon the particular objective, your task will be to provide perceptions of the person's maturity in performing each major objective.

Before completing the rating forms, it is essential for you to reflect on your past interactions with the head nurse in reference to quality of work output and attitudes. Think of specific projects and times on those projects when you were extremely pleased or displeased with the head nurse. Also, think how you typically perceived the person in terms of accomplishing each objective.

Maturity Scale (continued)

Directions:

1. Considering the first objectives only, select the five (5) most important Job Maturity dimendions (from the 7 provided), and "rate" the head nurse on each, using the following scale:

High			Moderate			Low	
8	7	6	5	4	3	2	1
M4			M3		M2	M1	

-Your ratings, ranging from 1 to 8 should be placed on the Response Sheet. To help you with the ratings, each area is defined with examples of "high" and "low" maturity.
-Be sure to base ratings on your observations of the head nurse's behavior.

2. Repeat the same rating task for each additional objective, one at a time.

-Please remember that you may choose different maturity dimensions (5 Job and 5 Psychological) for each objective, if you feel it is appropriate to do so.

Example:

Based on _____'s (Dimension), how do you see him or her?

Major Objectives:

1. Participating in and overseeing care given to patients.
2. Facilitating intra and interdisciplinary team functions.
3. Providing leadership and stimulating staff growth and satisfaction.
4. Developing and renewing plans for operation of the unit.
5. Developing own competencies in nursing and related areas.

Job Maturity Example:

Dimension:	Dimensions Defined:
Job Knowledge	(8) Possesses necessary job knowledge. (1) Does not have necessary job knowledge.

Maturity Scale (continued)

Psychological Maturity Example:

Dimension:	**Dimensions Defined:**
Work Attitude	**(8) Sees work as an enjoyable activity.** **(1) Has a "thank goodness it's Friday" attitude.**

Copies of the Maturity Scale (Manager- Self Rating Forms) are available through the Learning Resources Corporation

8517 Production Avenue
San Diego, California 92121
(714) 454-3193
800-854-2143 (toll free except in California, Alaska and Hawaii)

APPENDIX D

Description of Major Objectives and Responsibility of Head Nurses for Leader Maturity Scale

Description of Major Objectives and Responsibilities of Head Nurses for Leader Maturity Scale

1. Participates in and oversees the care given to patients

   a. Assess the needs and progress of patients and families either alone or with members of the nursing staff, or students.

   b. Participates in direct patient care as necessary to meet or evaluate a patient's need for nursing, demonstrate care, or forward his own expertness in care.

   c. Reviews signs and symptoms and behavior, as well as response to care and treatment, with members of the medical and nursing staff and other disciplines active in care of the patient. Contributes to development of team plans for care and implementation of these plans. Uses a variety of means, such as inspection, nursing care plans, and audit of the nursing record, to do the review.

   d. Makes assignments to members of the nursing staff. Through assignments provides for effective and efficient care within the ability and needs of individual members.

   e. Knows research studies in patient care, teaching, or management which are being conducted in his/her program area and helps interpret these to members of the staff. Assesses the effect of research activities on patients and personnel and keeps the researcher and appropriate member of the administrative staff informed.

2. Facilitates intra- and interdisciplinary team functioning

   a. Operates effectively as a leader or a member in goal-oriented intra- and interdisciplinary meetings.

   b. Oversees the coordination of health care services provided by nurses and other members of the health care team, as indicated and appropriate.

   c. Provides for, or assists the patient and family in securing continuity of nursing.

   d. Recognizes some of the health needs of the community, particularly as these concern his/her area of specialization. Works with the health team and community members to find means for meeting the needs.

e. Establishes and maintains an effective system of communications within the nursing discipline.

f. Provides feedback to the nursing faculty in areas such as, progress of students, effect of teaching-learning activities on the clinical environment, extent to which the curriculum prepares nurses for practice, and trends in the area of specialization.

3. Provides leadership which stimulates self-growth and satisfaction

a. Assists with recruitment of nursing staff to the hospital and his/her specialty. Interviews candidates as requested and recommends selection. Assists with the recruitment of students to nursing. Has a plan for orientation of nuw members of the staff. Helps each team member learn his/her particular role on the unit. This includes students.

b. Assumes responsibility for formal and informal teaching in his/her area of specialization. Learners might be members of the nursing staff; nursing, medical, pharmacy, or other students; interns or residents; or members of the community.

c. Works with clinical instructors in planning current and future experiences for Nursing Inservice, School of Nursing, or Continuing Education, and other students.

d. Appraises the performance of each member of the staff, provides feedback on good performance and counsel on areas for improvement, as the need arises. Effectively recommends recognition of performance and other personnel actions.

e. Plans and conducts (or participates in) unit staff meetings regarding policies, procedures, new Hospital information, problems or cases of interest to the work group. Elicits participation in other inservice or continuing education meetings.

f. Provides a climate in which staff openly discuss problems and ideas in a way which results in learning and growth.

g. Promotes effective interpersonal and interdisciplinary relationships. Is aware of individual's needs and resources. Develops a sense of personal worth, understanding of self and others, and tolerance.

h. Stimulates and encourages members of the staff to participate in the leadership role.

i. Assumes the responsibility for recognizing a nurse's potential for the role of head nurse and helps develop the potential.

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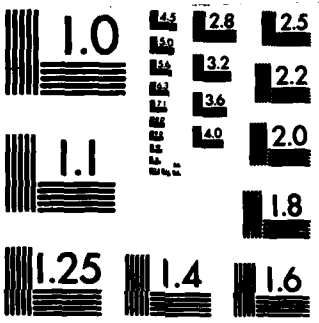


j. Teaches and guides each member of the staff to focus on personal and professional development to increase his/her expertness in performance and satisfaction.

k. Appreciates and applies teaching-learning principles to his/her instruction of personnel and students. Shows interest in using some of the newer communication media in teaching.

4. Develops and renews the plans for operation of the unit

a. Appreciates changing total nursing service needs and is able to establish priorities for his/her own unit in relation to the needs of others.

b. Establishes a staffing pattern for the unit. Schedules hours for personnel in accord with the plan, and with classification and personnel policies. Adjusts the plan to meet needs of patients, the employee, and the total group.

c. Appreciates there are different methods of organization and studies new methods. Implements and evaluates promising methods.

d. Utilizes the nursing unit clerk as an administrative assistant and delegates the full range of work appropriate to the position.

e. Cooperates in establishing an effective system for securing materials. Sees that equipment and the environment are maintained at a safe level. Participates in planning new or remodeled facilities.

f. Directs activities of the unit's nursing staff in the safety and disaster programs.

5. Develops own competence on nursing and related areas

a. Takes responsibility for initiating his/her own plan for self development and for identifying and implementing means for career satisfaction.

b. Engages in activities with peers which result in mutual sharing and support.

APPENDIX E

Personal Inventory Tool

Self

Personal Inventory Tool
Self

Directions:

Please complete each item on the following Personal Inventory Tool which is to be used to further describe leader characteristics of head nurses.

1. Age:_____.

2. Designated title of your position:_____.

3. Date of appointment to present position: Year:_____ Month:_____.

4. Sex: Female:____Male:_____.

5. Basic educational preparation in nursing: (check and complete only one)

   ____Associate Degree-Year Granted:_____.

   ____Diploma-Year Granted:_____.

   ____Baccalaureate Degree-Year Granted:_____.

   _____Masters Degree in _____-Year Granted:_____.

6. What additional educational credits have you earned beyond your basic educational program listed in number 5 above? (check and complete all that apply)

   ____Number of credits earned:_____.

   _____Baccalaureate Degree in Nursing-Year Granted:_____.

   _____Baccalaureate Degree in_____-Year Granted:_____.

   _____Anticipated Date of Completion of Baccalaureate Degree in

   _____.

   ____Masters Degree in _____.

7. Have you had leadership training beyond that offered in your basic educational program listed in number 5 above?

   _____Yes _____No

If your answer is yes, please complete the following information:

Title of the training:_____.

Institution offering the training:_____.

Length of the training course:_____.

Content of the course:_____.

8. What was your professional work experience prior to your present appointment?

   Please list in chronological order from present to past.
   (You may use the back of this page should you need additional space)

   DATE: INSTITUTION: POSITION:

9. What was your prior leadership experience prior to your present appointment?

   Please list in chronological order from present to past.
   (You may use the back of this page should you need additional space)

   a. Nursing:

      DATE: POSITION:

   b. Other:

      DATE: ORGANIZATION: OFFICE HELD:

10. How many staff are directly responsible to you in your present position as head nurse?

    Registered Nurses: Full time:_____ Part time:_____.

LPN's: Full time:_____ Part time:_____.

Aides-Attendants-Orderlies: Full time:_____ Part time:_____.

Other: (Please list)_____ Full time:_____ Part time:____

11. What type of care is delivered on your unit? (check all that apply)

_____*primary care

_____*secondary care

_____*tertiary care

* = Definitions:

Primary Care: "The usual point of entry in to the health care system; it is oriented toward the promotion and maintenance of health, prevention of disease, and care of individuals with common health problems, uncimplicated illnesses, chronic latent illness, and selected aspects of complicated illness in the home or outpatient setting. Care is given on a family basis with professionals providing guidance in the use of health resources and referring to other levels of the health care system" (Chioni & Panicucci, 1970).

Secondary Care: "Individuals enter this level directly or more commonly, through referral. It is oriented toward the care of individuals in a specified range of illness or pathology. Care is given in any health care setting by professionals who have refined their knowledge and skill in an area of concentration. Promotion and maintenace of health care are limited to the professional's area of competence" (Chioni & Panicucci, 1970).

Tertiary Care: "Individuals enter this level by referral from either the primary or secondary level. It is oriented toward the care of individuals or families with complex or complicated health needs. Care may be given in any health setting by professionals who have highly refined knowledge and skill in a clinical specialty area. Promotion and amintenance of health are limited to the professional's area of specialization" (Chioni & Panicucci, 1970).

APPENDIX F

Personal Inventory Tool

Superior

Personal Inventory Tool

Superior

Directions:

Please complete each item on the following Personal Inventory Tool which is to be used to describe those others with whom the head nurse works:

1. Age:_____.

2. Designated title of your position:_____.

3. Date of appointment to present position: Year:_____ Month:_____.

4. Sex: Female:_____ Male:_____

5. Basic education preparation: (check and complete only one).

   _____Associate Degree-Year Granted:_____.

   _____Diploma - Year Granted:_____.

   _____Baccalaureate Degree - Year Granted:_____.

   _____Masters Degree in _____ - Year Granted:_____.

6. What additional educational credity have you earned beyond your basic educational list in number 5 above? (Check and complete all that apply).

   _____Number of credits earned:_____.

   _____Baccalaureate Degree in_____- Year Granted:_____.

   _____Anticipated Date of Completion of Baccalaureate Degree in _____.

   _____Masters Degree in_____- Year Granted:_____.

7. Have you had leadership training beyond that offered in your basic educational program listed in number 5 above?

   _____Yes _____No

If your answer is yes, please complete the following information:

Title of the training:_____.

Institution offering the training:_____.

Length of the training course:_____.

Content of the course:_____.

8. What was your professional work experience prior to your present appointment?

   Please list in chronological order from present to past. (You may use the back of this page should you need additional space).

   DATE: INSTITUTION: POSITION:

9. What was your prior leadership experience prior to your present appointment?

   Please list in chronological order from present to past. (You may use the back of this page should you need additional space).

   a. Nursing:

      DATE: POSITION:

   b. Other:

      DATE: ORGANIZATION: OFFICE HELD:

10. How many staff are directly responsible to you in your present position?

Registered Nurses: Full time:_____ Part time:_____.

LPN's: Full time:_____ Part time:_____.

Aides-Attendants- Orderlies: Full time:_____ Part time:_____.

Other: (Please list) _____ Full time:_____.

Part time:_____.

APPENDIX G

Personal Inventory Tool

Subordinates

Personal Inventory Tool

Subordinates

Directions:

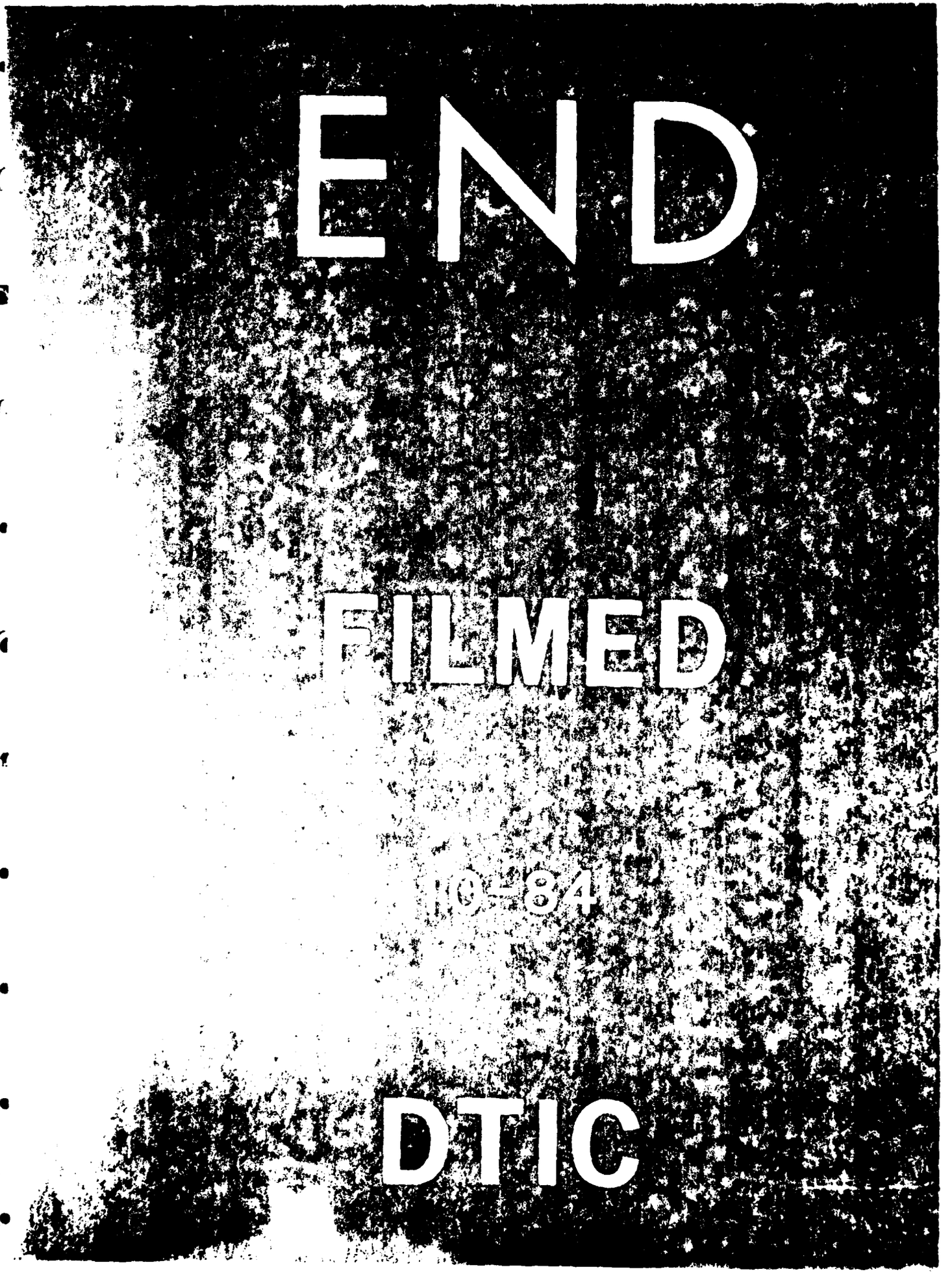
Please complete each item on the following Personal Inventory Tool which is to be used to describe those others with whom the head nurse works.

1. Age:_____.

2. Designated title of your position:_____.

3. Date of appointment to present position: Year:_____ Month:_____.

4. Sex: Female_____ Male_____.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